Tillamook Bay DENTAL

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____
Date _____
Patient's Sex ☐F ☐M

Patient Medical History (Confidential)

Name _____ Preferred Name _____ Birthdate _____ SS#/SIN _____
Mailing Address _____ City _____ State _____ Zip _____
Email _____ Home Phone _____
Do you prefer to receive calls at your: ☐Home ☐Work ☐Cell Phone Cell Phone _____
Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Patient or Parent's Employer _____ Work Phone _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License# _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this Person Currently a Patient in our Office? ☐Yes ☐No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐Cash ☐Personal Check ☐Credit Card ☐VISA ☐Mastercard ☐I wish to discuss the office's payment policy

Are you currently covered by any of the following:
☐Oregon Health Plan ☐Private Insurance ☐Care Credit ☐ Other _____
☐Supplemental (Aflac, Discount Card, etc.) ☐None

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐Yes ☐No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

Tillamook Bay Dental

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○Yes	○No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	○Yes	○No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	○Yes	○No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	○Yes	○No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	○Yes	○No	_____
Have you even taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○Yes	○No	_____
Are you on a special diet?	○Yes	○No	
Do you use tobacco?	○Yes	○No	
Do you use controlled substances?	○Yes	○No	

Women: Are you Pregnant/Tryng to get pregnant? ○Yes ○No Taking oral contraceptives? ○Yes ○No Nursing? ○Yes ○No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○Yes	○No	Cortisone Medicine	○Yes	○No	Hemophilia	○Yes	○No	Radiation Treatments	○Yes	○No
Alzheimer's Disease	○Yes	○No	Diabetes	○Yes	○No	Hepatitis A	○Yes	○No	Recent Weight Loss	○Yes	○No
Anaphylaxis	○Yes	○No	Drug Addiction	○Yes	○No	Hepatitis B or C	○Yes	○No	Renal Dialysis	○Yes	○No
Anemia	○Yes	○No	Easily Winded	○Yes	○No	Herpes	○Yes	○No	Rheumatic Fever	○Yes	○No
Angina	○Yes	○No	Emphysema	○Yes	○No	High Blood Pressure	○Yes	○No	Rheumatism	○Yes	○No
Arthritis/Gout	○Yes	○No	Epilepsy or Seizures	○Yes	○No	High Cholesterol	○Yes	○No	Scarlet Fever	○Yes	○No
Artificial Heart Valve	○Yes	○No	Excessive Bleeding	○Yes	○No	Hives or Rash	○Yes	○No	Shingles	○Yes	○No
Artificial Joint	○Yes	○No	Excessive Thirst	○Yes	○No	Hypoglycemia	○Yes	○No	Sickle Cell Disease	○Yes	○No
Asthma	○Yes	○No	Fainting Spells/Dizziness	○Yes	○No	Irregular Heartbeat	○Yes	○No	Sinus Trouble	○Yes	○No
Blood Disease	○Yes	○No	Frequent Cough	○Yes	○No	Kidney Problems	○Yes	○No	Spina Bifida	○Yes	○No
Blood Transfusion	○Yes	○No	Frequent Diarrhea	○Yes	○No	Leukemia	○Yes	○No	Stomach/Intestinal Disease	○Yes	○No
Breathing Problem	○Yes	○No	Frequent Headaches	○Yes	○No	Liver Disease	○Yes	○No	Stroke	○Yes	○No
Bruise Easily	○Yes	○No	Genital Herpes	○Yes	○No	Low Blood Pressure	○Yes	○No	Swelling of Limbs	○Yes	○No
Cancer	○Yes	○No	Glaucoma	○Yes	○No	Lung Disease	○Yes	○No	Thyroid Disease	○Yes	○No
Chemotherapy	○Yes	○No	Hay Fever	○Yes	○No	Mitral Valve Prolapse	○Yes	○No	Tonsillitis	○Yes	○No
Chest Pains	○Yes	○No	Heart Attack/Failure	○Yes	○No	Osteoporosis	○Yes	○No	Tuberculosis	○Yes	○No
Cold Sores/Fever Blisters	○Yes	○No	Heart Murmur	○Yes	○No	Pain in Jaw Joints	○Yes	○No	Tumors or Growths	○Yes	○No
Congenital Heart Disorder	○Yes	○No	Heart Pacemaker	○Yes	○No	Parathyroid Disease	○Yes	○No	Ulcers	○Yes	○No
Convulsions	○Yes	○No	Heart Trouble/Disease	○Yes	○No	Psychiatric Care	○Yes	○No	Venereal Disease	○Yes	○No
									Yellow Jaundice	○Yes	○No

Have you ever had any serious illness not listed above? ○Yes ○No _____

Comments: _____

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved.
This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X _____

Signature of patient (or parent/guardian if minor) Date